Guardian Decision Regarding Waiver Services

Consumer Name: _____

Address: _____

_____

I understand my right to choose between Community Based Waiver Services and ICF/MR Services for the person listed above for whom I am Legal Guardian. The Department Designee listed below has explained the difference between these two types of service to me. The Department Designee has also explained that if my request for Community Based Waiver Services is denied, I have the right to appeal that decision in accordance with Department policies and State law.

_____ In agreement with the Annual Plan developed on _____, I would like to select Waiver Services as specified in the Individual Plan.

_____ I would like to select Waiver Services as specified in the Annual Plan of _____ except for _____.
(Specify service not desired)

_____ I would like ICF/MR Services.

_____	_____	_____
Guardian/Self	Printed Name	Date
_____	_____	_____
ISC/Dept. Designee	Printed Name	Date
_____		_____
(Advocate signature, if consumer is under DHHS Guardianship)		Date

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